Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METROPLEX ORTHOPEDICS
9262 FOREST LANE SUITE 101
DALLAS TEXAS 75243

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-04-2060-01

MFDR Date Received
October 13, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the medical fee guidelines, we feel our claims should have been processed according to page 67, section five-surgical procedures performed in a doctor's office. Our claims and documentation met all of the requirements listed and that is generally the way our claims are processed."

Amount in Dispute: $1,255.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to Commission rule 133.307 (e)(2) sections (A) through (C) and 133.307 (E)(3) the TMIC files the attached, completed TWCC-60 and related items."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2003	Radiology codes, supplies, injections, and post operative monitoring	$1,255.98	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §134.201(a), effective April 1, 1996 sets out the Texas Workers' Compensation Commission Medical Fee Guideline.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 29, 2003
   - YG – Reimbursement for this procedure is included in the basic allowance for another procedure
   - YF – Reduce or denied in accordance with the appropriate fee guideline ground rule and/or maximum allowable reimbursement (MAR).
   - 18 – The charge for the technical component of the procedure exceeds the scheduled allowance
   - JF – Documentation submitted does not substantiate the service billed.

Issues

1. Did the requestor meet the Documentation of Procedure (DOP) requirements?
2. Did the requestor document the billed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per Medical Fee Guideline 1996, General Instructions III A, "Documentation of procedure (DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation attached to or included in the bill. DOP is used when the services provided are not specifically listed or are unusual or too variable to have an assigned MAR. The required documentation may vary based on the complexity of the procedure. DOP shall include pertinent information about this procedure including: 1. Exact description of procedure or service provided; 2. Nature, extent, and need (diagnosis and rationale) for the service or procedure; 3. Time required to perform the service or procedure; 4. Skill level necessary for performance of service or procedure; 5. Equipment used (if applicable); and 6. Other information as necessary."

   Medical Fee Guideline 1996, General Instructions VI provides that "CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate. HCPCS codes shall be reimbursed as provided in the DME Ground Rules. In the event of a dispute, fair and reasonable shall be determined by the Commission in accordance with the Texas Worker's Compensation Act and Commission rules and procedures.

   This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission.

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC codes A4645, J0690, J2000, 99070-AS, 99070-ST, and 99499-RR.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for codes HCPC codes A4645, J0690, J2000, 99070-AS, 99070-ST, and 99499-RR.

2. The requestor did not submit documentation to support the billing of CPT codes 72020-27 x 3, 72020 and 72295. Reimbursement cannot be recommended for disputed CPT codes 72020-27, 72020 and 72295.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.